FINAL REPORT
OF THE
INTERIM STUDY COMMITTEE ON
MEDICAID SUPPLEMENTAL PROGRAMS

Indiana Legislative Services Agency
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I. STATUTORY DIRECTIVE

The Indiana General Assembly enacted HEA 1194-2009 establishing the Interim Study Committee on Medicaid Supplemental Programs to study the following issues: (1) federal intergovernmental transfer leveraging and alternative revenue generating options if currently used leveraging is determined by the federal government to be invalid; (2) the merits and effect of expanding the Indiana Check-Up Plan established by IC 12-15-44.2-3 to cover additional childless adults through a federal Medicaid waiver or Medicaid state plan amendment.

II. INTRODUCTION AND REASONS FOR STUDY

HEA 1194-2009 directed the Family and Social Services Administration to develop and maintain an electronic format that displays the applicable federal and state laws, rules, regulations, and policies along with specified data relating to the Hospital Care for the Indigent (HCI) program, Upper Payment Limit program (UPL), and the Disproportionate Share Hospital (DSH) program. The statute also directed the Committee to study issues involving these three programs.

In 2007, the federal Department of Health and Human Services proposed a rule that would have changed the definition of a unit of government for the purposes of intergovernmental transfers (IGTs). The proposed rule would have made other changes that would have affected how states conduct IGTs. In 2008, nearly $800 M in supplemental payments was made to certain Indiana hospitals. HEA 1194-2009 recognized the potential for significant negative fiscal impact for the hospitals that assume the highest levels of care for Medicaid patients and low-income individuals if the proposed rule was promulgated. The Interim Study Committee on Medicaid Supplemental Programs was directed in the bill to study the issue. The federal rule was subsequently nullified as the result of a court action and the Obama Administration has not attempted to restart the rule-making process on these proposed rules.

The Indiana Check-up Plan established by HEA 1608-2007 authorized the Healthy Indiana Plan (HIP) Medicaid waiver to provide healthcare coverage for certain low-income individuals previously not eligible for Medicaid coverage. By the end of CY 2008, the first year the plan was available, it was clear that individuals classified as childless adults were rapidly filling the available limited waiver slots. The childless adult category was limited to 34,000 individuals within the waiver by the federal Centers for Medicare and Medicaid Services (CMS) during negotiations with the Administration on Medicaid waiver budget neutrality requirements. The Interim Study Committee on Medicaid Supplemental Programs was directed by HEA 1194-2009 to study the possibility of expanding the number of childless adults covered under the Healthy Indiana Plan.

III. SUMMARY OF WORK PROGRAM

The Committee met twice during the 2009 interim. Both Committee meetings were held at the State House in Indianapolis.

The first meeting was held October 6, 2009. Mr. Doug Elwell, FSSA, gave an overview of the basic Medicaid supplemental payment programs, consisting of the HCI program, the UPL program, and the DSH program. The presentation included information on eligibility determination and the distribution of funds made in FY 2007 through FY 2009. FSSA also demonstrated the location of information concerning the supplemental payment programs that is being added to the agency web page as required by HEA 1194-2009. Ms. Casey Kline, LSA Staff Attorney, provided an overview of IGTs under the Medicaid Program and summarized actions concerning the proposed federal rule that would have affected how states conduct IGTs. Ms. Seema Verma, FSSA, provided the Committee with an update on HIP, and Ms. Pat Casanova, Director of the Office of Medicaid Policy and Planning (OMPP), gave an update on the Medicaid Medical Review Team backlog.

The second meeting was held October 27, 2009. The meeting was for the purpose of hearing additional information on the DSH and HIP programs that was requested at the first meeting, to discuss and consider recommendations, and to adopt the Committee's final report. Ms. Pat Casanova, OMPP responded to a question concerning the HIP waiver and Ms. Pat Nolting reviewed data comparing HIP hospital paid claims to DSH payments for FY 2009. Ms. Seema Verma discussed funding projections of possible HIP expansions, disposition of federal ARRA stimulus DSH funds, and the HIP II plan.

IV. SUMMARY OF TESTIMONY

Medicaid Supplemental Hospital Payment Programs

The Committee heard testimony from Mr. Doug Elwell of FSSA who presented an overview of how the Medicaid supplemental payment programs are administered. Mr. Elwell explained that the supplemental payment programs occur within the state Medicaid program and that eligible funding must be provided for the state share of any Medicaid payment in order to leverage the federal funds. The state share can be provided by qualified intergovernmental transfers, qualified certified expenditures, and state general funds.

Hospital Care for the Indigent Program

Mr. Elwell explained that the HCI program is named for the original source of the funds used to support the program - a county property tax levy. The levy was eliminated and replaced with state general funds by HEA 1001-2008 enacted for property tax relief. Previously, HCI distributions were made by a variety of methods as the state statute governing the program changed over time. Information included in handouts given to the Committee indicated that in 2008 and 2009, CMS did not approve the methodology

required by the current state statute. Consequently, federal matching funds were not available and no HCI distribution was made for either of those years. Mr. Elwell testified that after the state takes $30 M for regular Medicaid as required by the statute, any remaining funds from the HCI program are now distributed to the DSH or the UPL programs to be used as the state share to leverage federal funds within those programs.

Disproportionate Share Hospital Program

Eligibility:
Mr. Elwell stated that DSH eligibility is not determined each year but is determined for federally defined eligibility periods of at least two years and not more than four years. He explained that the last DSH eligibility period was for four years that ended in 2009. He testified that the next eligibility period beginning in 2010 will be for two years. This is significant because in Indiana a hospital must be determined to be a DSH hospital in order to participate in the DSH program or the UPL program. He also explained the process used to collect the data used to calculate the DSH eligibility and stated that the current plan is to use the 2009 hospital cost report data to determine the DSH-eligible hospitals for 2010 DSH and UPL supplemental payments.

Eligibility Calculations:
Mr. Elwell explained that there are two ways for a hospital to qualify for DSH eligibility. The first is the Low-Income Utilization Rate (LIUR). The LIUR is calculated by comparing the amount of total low-income and Medicaid payments to the total payments received by the hospital. He commented that since Methodist Hospital in Gary combined its license with the Southlake Hospital, only psychiatric hospitals and Wishard qualify as LIUR hospitals. Most hospitals qualify for DSH status using the Medicaid Inpatient Utilization Rate (MIUR), which is calculated by dividing a hospital's inpatient Medicaid days by the total inpatient days. After removing the utilization rates for LIUR qualifying hospitals, the rates are arrayed and those hospitals with a rate determined to be one standard deviation above the statewide mean rate are classified as DSH hospitals for the eligibility period.

Eligibility Shares:
Mr. Elwell explained that state law requires that newly eligible DSH hospitals receive one-third of the hospital's cap in the first eligibility period, two-thirds of the cap in the second continuous eligibility period, and the full cap in the third continuous eligibility period.

DSH Caps
Mr. Elwell stated that under the DSH program the state has a federally defined allocation of DSH funds. This was approximately $212 M in FY 2008. Individual hospitals also have a cap that is the amount by which their Medicaid costs exceeded their Medicaid payments, including any HCI and UPL payments, plus the cost of uninsured care less any related payments. A hospital cannot receive DSH payments in excess of their cap. In Indiana the accumulated hospital caps are more than the state

DSH allocation. Mr. Elwell stated that institutions for mental diseases (IMDs) and municipal hospitals may also receive DSH funds. He added that there is not enough DSH funding to meet the caps of all the eligible hospitals.

DSH Order of Payments

Federal rules limit DSH distributions for IMDs to one-third of the total state DSH cap. The IMDs are the state-operated facilites and private psychiatric hospitals. In Indiana, the private psychiatric DSH providers split a defined pool of $2 M, while the state facilities receive the remainder. Under negotiated Medicaid waiver terms concerning federal budget neutrality, the Healthy Indiana Plan is allocated $50 M of the state DSH allocation. The remainder is available for distribution to the DSH-eligible hospitals.

Upper Payment Limit Program

Mr. Elwell explained that federal Medicaid rules allow states to pay up to the amount Medicare pays for a service. Since Indiana Medicaid pays less than Medicare, the state is allowed to make supplemental payments up to the amount that Medicare would have paid for the services. The UPL program is divided into six mutually exclusive categories: inpatient and outpatient state-owned facilities; inpatient and outpatient private facilities; and inpatient and outpatient non-state government-owned facilities. He added that within each of the six categories, the UPL program does not require a cap on payments to individual hospitals as long as the payments are within the total state caps for the category and do not exceed the hospital's charges. In Indiana, participation in the UPL program is limited to DSH-eligible hospitals.

HCI, UPL, and DSH Payments

Mr. Elwell reviewed handouts to the Committee that detailed by hospital and UPL classification, the order that payments were made from the programs - HCI first, UPL second, DSH last. (See the minutes and attachments from the meeting of October 6, 2009.)

Mr. Tom Fischer, CFO for Community Health Network, commented that the DSH program is complex and it is difficult to get information regarding calculations and qualifying data. He stated that the program needs to be as transparent as possible. He also testified that DSH qualifying hospitals should be treated equally with regard to the amount of the distribution. Currently, the statute requires that only hospitals that have qualified for at least three eligibility periods are eligible to be paid to the full cap while newly qualified hospitals are eligible for only one-third of the cap. Hospitals qualified for two consecutive eligibility periods are eligible for two-thirds of the cap. Mr. Fischer also mentioned that the eligibility periods should be as short as possible; the last eligibility period of four years was too long.

Ms. Bernita Drayton testified that she is a secretary at Methodist Hospital in Gary and a union member. She stated that it is crucial to provide resources to safety net hospitals and that funding levels for safety net hospitals should at the least remain at constant levels.

Intergovernmental Transfers

Ms. Casey Kline, LSA Staff Attorney, provided the Committee with an overview of the federal actions that led to the nullification of the proposed rule that would have affected how states conduct IGTs. She explained that after Congress passed a law that placed a moratorium on proposed rules that would have changed the definition of a unit of government for the purposes of IGT, CMS tried to implement the rule by publishing it before the President signed the bill containing the moratorium. A federal district court nullified the proposed rule and the Obama Administration has not attempted to re-promulgate the rule.

Healthy Indiana Plan

The Committee received data showing the distribution of HIP hospital payments compared to what the hospitals would have received if DSH distributions had been made in 2009. The data demonstrated that in total, HIP hospital paid claims exceeded the amount of the DSH distributions that were foregone in order to provide federal budget neutrality for the inclusion of coverage for childless adults. The distribution of the paid claims differed from DSH allocations because HIP-covered individuals choose the hospitals that they receive services from; the hospitals they choose may not be the same facilities that would have received DSH distributions. The data presented did not include HIP claims paid to physicians and other nonhospital providers.

Ms. Seema Verma, a contractor for FSSA, provided the Committee with an update on HIP. She informed the Committee that CMS had allowed the population of 34,000 childless adults in the HIP program only because of the application of $50 M in DSH funds to the HIP program. Ms. Verma testified that there are approximately 47,000 individuals enrolled in HIP; approximately 26,000 are childless adults. She added that administrative requirements had prevented FSSA from opening the enrollment for childless adults but that they would be starting to contact individuals on the waiting list for plan enrollment within a few weeks. She suggested that the HIP crowd-out provisions or access to employer-sponsored health insurance might be responsible for the prevalence of individuals with lower income levels participating more than originally anticipated.

Ms. Verma stated that FSSA has requested CMS to approve an additional 7,000 childless adult slots in the program using savings estimated to accrue from the Medicaid pharmacy consolidation to produce the necessary budget neutrality. CMS has not responded to the request for additional waiver slots. She testified that due to the uncertainty surrounding the outcome of federal healthcare reform, the addition of the 7,000 additional childless adult slots is the only HIP eligibility change or expansion that FSSA would propose for the next two to three years. She also stated that no changes were contemplated for the DSH or UPL programs for the same reason.

In response to a question regarding how HIP eligibility determinations were being funded, Ms. Verma stated that HIP eligibility determinations are performed by a separate unit within Affiliated Computer Services (ACS), a subcontractor of IBM within the eligibility modernization contract. HIP eligibility processing is paid with cigarette tax dollars on a per-application basis.

In response to questions about the disability status of individuals applying for and receiving HIP, Ms. Verma responded that participation in HIP does not require an asset limitation, nor does it require a medical record review. The HIP application process does not collect data that would allow screening out disabled individuals. If an individual previously participated in Medicaid with a spend-down, then FSSA has the information needed to disallow participation in HIP. She added that a disabled individual could quickly exhaust the HIP annual and lifetime coverage limitations. She referred to Table 2, and Special Terms and Condition (STC) #19 of the waiver document at: http://www.in.gov/fssa/files/IN_-_Healthy_Indiana_Plan_(HIP).pdf.

Ms. Verma reported to the Committee that the additional DSH funds attributable to the federal ARRA stimulus were required by CMS to be applied towards the HIP waiver budget neutrality requirement for 2009. She stated that FSSA had requested that the additional ARRA funds be paid to DSH hospitals in 2010. CMS has not responded to the request at this time.

Ms. Verma reported a correction of earlier testimony regarding interest paid on the Indiana Check-Up Plan Trust Fund. She stated that interest on the fund had been reverted to the General Fund because the enabling statute did not protect the interest. Ms. Kline, LSA Staff Attorney, stated that the enabling statute did not mention the interest income and that other statutes specify the disposition of the interest earned on nonreverting funds. The Committee decided to address this issue as a recommendation.

Medicaid Medical Review Team Update

Ms. Pat Casanova, OMPP Director, testified that FSSA has hired additional staff and contracted for assistance with the medical review backlog.

V. COMMITTEE FINDINGS AND RECOMMENDATIONS

The Committee made the following legislative recommendation:

There was a motion for the Committee to recommend proposed draft legislation providing that interest accruing to the Indiana Check-Up Trust Fund remain in the fund and not revert to the state General Fund. The motion prevailed by a vote of 9-0.

The Committee made the following recommendations:

The Committee voted 9-0 to recommend that the Select Joint Commission on Medicaid Oversight be given a report on the balance of the Indiana Check-Up Plan Trust Fund.

The Committee voted 9-0 to adopt the final report as drafted with the inclusion of the Committee recommendations and incorporating the actions of the final meeting.

W I T N E S S L I S T

Lou Belch, representing Community Hospital East
Pat Casanova, Director, OMPP, FSSA
Bernita Drayton
Kristine Ellerbruch, OMPP, FSSA
Douglas Elwell, Contractor, Family and Social Services Administration
Thomas Fischer, Chief Financial Officer, Community Health Network
Casey Kline, Esq., Staff Attorney, Legislative Services Agency
Robin, Ledyard, MD., President, Community Hospital East
Anne Murphy, Secretary, Family and Social Services Administration
Pat Nolting, Reimbursement Director, OMPP, FSSA
Seema Verma, Consultant, Family and Social Services Administration